Counseling Specialists
OF CENTRAL FLORIDA

CHILD INTAKE QUESTIONNAIRE

GENERAL INFORMATION

Date: _____

Last Name: _____ First Name: _____ Middle Initial: ____

Nickname: _____ Suffix: _____ Date of Birth: _____ Age: _____

Race/Ethnicity: _____ Sex: ☐ Male ☐ Female

Name of Parent(s)/Guardian(s): _____

EDUCATION INFORMATION

What is the highest grade completed? Check box below:

Elementary: ☐ K ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 School: _____

Middle School: ☐ 6 ☐ 7 ☐ 8 School: _____

High School: ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ GED School: _____

Were you ever held back a grade(s), skipped a grade(s) and/or homeschooled? ☐ Yes ☐ No

MILITARY/FIRST RESPONDER INFORMATION

Has your parent(s) ever served in the military? Father: ☐ Yes ☐ No Mother: ☐ Yes ☐ No

Current Status: ☐ Enlisted ☐ Reserves ☐ Retired ☐ Discharged: _____

Branch of Service: ☐ Army ☐ Navy ☐ Air Force ☐ Marines ☐ Coast Guard

First Responder: ☐ FBI/CIA ☐ LEO ☐ EMT/Fireman ☐ Dr/Nurse/ER ☐ 911 Operator

Years of Service: _____ Injuries Received: _____ Ongoing Issues: ☐ Yes ☐ No

RELATIONAL INFORMATION

With whom do you currently reside? (Check all that apply)

☐ Biological parent(s) ☐ Step-parent(s) ☐ Foster parent(s) ☐ Adoptive parent(s)

☐ Grandparent(s) ☐ Sibling(s) ☐ Girlfriend ☐ Boyfriend

☐ Friend(s) ☐ Pet(s) ☐ Other(s): _____

PRESENTING ISSUES AND GOALS

Briefly describe the current concerns, problems, and symptoms:

_____

_____

What do you hope to gain or change by coming to counseling?

_____

_____

Over the past six (6) months have the symptoms: ☐ Improved ☐ Worsened ☐ No change

Are your currently experiencing any problems in the following aspects of your life? If so, please explain:

☐ Family/Legal: _____

☐ Educational/Occupational: _____

☐ Social/Driving: _____

Is there anything that helps reduce the problem(s) or symptom(s)? If so, please describe:

_____

_____

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Is there anything that seems to make the symptom(s) or problem(s) worse? If so, please describe:

_____

_____

Have you been receiving treatment to address your concerns? If so, has it been helpful? Please describe:

_____

_____

LEVEL OF DISTRESS

On a scale of 1 – 10, indicate how distressed you are with 10 being the highest level of distress: _____

Are you currently experiencing any self-harming thoughts/behaviors? ☐ Yes ☐ No

Frequency: _____ Intensity (1 – 10 Scale): _____ Duration (how many hours/days): _____

Are you currently experiencing any suicidal thoughts? ☐ Yes ☐ No

Frequency: _____ Intensity (1 – 10 Scale): _____ Duration (how many hours/days): _____

Have you experienced either of them in the past? ☐ Yes ☐ No

If yes, explain: _____

Do you currently have a plan for self-harming? ☐ Yes ☐ No

If yes, explain: _____

Have you ever attempted suicide? ☐ Yes ☐ No

If yes, dates of attempt(s): _____

Describe attempt(s) and outcome(s): _____

Is there a family history of self-harming and/or suicide attempts/gestures/completions? ☐ Yes ☐ No

If yes, describe, including relationship(s) to client: _____

Are you currently experiencing any violent thoughts or have a history of destructive behaviors? ☐ Yes ☐ No

If yes, explain: _____

Do you have a history of legal issues? ☐ Yes ☐ No

If yes, explain: _____

Do you have a probation officer? ☐ Yes ☐ No

If yes, explain: _____

PROTECTIVE FACTORS

- ☐ Religious beliefs
- ☐ Future focused
- ☐ Social support(s)
- ☐ Maintains positive relationships
- ☐ History of seeking help during crisis
- ☐ Frustration tolerance
- ☐ Absence of a plan, means, and/or intent
- ☐ Responsible for siblings and/or pets
- ☐ Willingness to engage in treatment
- ☐ Other information: _____

RELIGIOUS BACKGROUND

Do you believe in God? ☐ Yes ☐ No Who or what provides you with strength and hope? _____

Have religious or spiritual beliefs been important in your life? ☐ Yes ☐ No

Do you attend a place of worship? ☐ Yes ☐ No

If yes, where: _____ How often do you attend: _____

Did you have a religious upbringing? ☐ Yes ☐ No

Who provides your support system? _____ Any recent changes? ☐ Yes ☐ No

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SYMPTOMS & CONCERNS

Please check each symptom that applies and add comments below as needed.

Attention & Concentration

- ☐ Difficulty paying attention to things
- ☐ Difficulty maintaining concentration
- ☐ Losing my train of thought easily
- ☐ Difficulty doing more than one thing at a time
- ☐ Difficulty following instructions or directions
- ☐ Being distracted by my own thoughts
- ☐ Being distracted by noises or the environment
- ☐ Having my mind go blank frequently
- ☐ Becoming easily confused and disoriented
- ☐ Slow thinking speed

Problem Solving & Organization

- ☐ Difficulty solving problems that others could manage
- ☐ Difficulty figuring out how to do new things
- ☐ Difficulty completing an activity in a reasonable time
- ☐ Difficulty doing things in the right order (sequencing)
- ☐ Difficulty organizing items for a project
- ☐ Difficulty problem-solving in social situations
- ☐ Difficulty changing a plan/activity as needed
- ☐ Difficulty planning steps for a project
- ☐ Difficulty thinking as quickly as needed

Word Finding & Naming

- ☐ Difficulty finding the word I want to say
- ☐ Forgetting names of family/close friends
- ☐ Difficulty learning new names
- ☐ Using wrong words when speaking
- ☐ Forgetting names of acquaintances

Speech & Language

- ☐ Difficulty understanding what others say
- ☐ Difficulty getting my speech started
- ☐ Change in the complexity of my speech
- ☐ Change in the speed of my speech
- ☐ Change in the clarity of my speech
- ☐ Change in the volume of my speech

Memory

- ☐ Loses or misplaces things
- ☐ Forget why I walked into a room
- ☐ Forget things that happened hours or days ago
- ☐ Forget events that happened months or years ago
- ☐ Rely more on notes to remember things
- ☐ Forget facts but can remember how to do things
- ☐ Forget how to do things
- ☐ Forget names
- ☐ Forget the content of conversations
- ☐ Forget if a conversation occurred

Academic Skills

- ☐ Difficulty understanding what I read
- ☐ Difficulty retaining what I read
- ☐ Difficulty with spelling, grammar, or punctuation
- ☐ Difficulty with mental math
- ☐ Difficulty with paper and pencil math
- ☐ Difficulty with handwriting

Sensory Symptoms

- ☐ Near sighted
- ☐ Astigmatism
- ☐ Difficulty with night vision
- ☐ See things that are not there
- ☐ Color blindness
- ☐ Hearing loss
- ☐ Hear strange sounds
- ☐ Hearing aids: if so, since what age: _____
- ☐ Taste: Increased sensitivity
- ☐ Smell: Increased sensitivity
- ☐ Touch: Increased sensitivity, including texture(s)
- ☐ Far-sighted
- ☐ Blurred vision
- ☐ Double vision
- ☐ Poor peripheral vision
- ☐ Wear glasses: if so, since what age: _____
- ☐ Ringing in ears
- ☐ Hearing loss
- ☐ Taste: Decreased sensitivity
- ☐ Smell: Decreased sensitivity
- ☐ Touch: Decreased sensitivity, including texture(s)

Motor Symptoms

- ☐ Weakness on one side of body
- ☐ Fine motor difficulties
- ☐ Difficulty with balance
- ☐ Muscle weakness
- ☐ Tremor or shakiness
- ☐ Tic or strange movements
- ☐ Muscle stiffness
- ☐ Difficulty walking

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Mood & Behavior

☐ Sadness or depression: if applicable, circle one	☐ Mild	☐ Moderate	☐ Severe
☐ Anxiety or nervousness: if applicable, circle one	☐ Mild	☐ Moderate	☐ Severe
☐ Anger: if applicable, circle one	☐ Mild	☐ Moderate	☐ Severe
☐ Oppositionality: if applicable, circle one	☐ Mild	☐ Moderate	☐ Severe
☐ Sleep problems: if applicable, circle one	☐ Failing asleep	☐ Staying asleep	☐ Both
☐ Appetite problems:	☐ Decreased	☐ Increased	☐ Restricting

ALCOHOL & SUBSTANCE USE/ABUSE

Do you currently drink alcohol? ☐ Yes ☐ No

Started drinking alcohol at age: _____ Frequency of alcohol use: _____

Last drink was: _____ If no longer drinking alcohol, date stopped: _____

Do you currently use drugs? ☐ Yes ☐ No

Started using drugs at age: _____ Frequency of drug use: _____

If no longer using drugs, date stopped: _____ I have been in drug treatment: ☐ Yes ☐ No

Do you currently smoke cigarettes? ☐ Yes ☐ No

Started smoking at age: _____ Frequency of cigarette use: _____ Amount per day: _____

Last time I smoked was: _____ If you no longer smoke, date stopped: _____

Do you currently use vaping products? ☐ Yes ☐ No

Started vaping at age: _____ Frequency of vaping use: _____ Amount per day: _____

Last time I vaped was: _____ If you no longer vape, date stopped: _____

Do you consume caffeinated drinks? ☐ Yes ☐ No

Amount per day: _____ Types of caffeinated drinks consumed: _____

PSYCHOSOCIAL HISTORY

You were born: ☐ On time ☐ Prematurely ☐ Late ☐ Unknown

You were born through: ☐ Vaginal delivery ☐ Cesarean section ☐ Unknown

Were there any problems with your mother's pregnancy and/or delivery with you? If so, describe:

_____

_____

Do you have any of the following issues:

☐ Attention problems	☐ Learning disability	☐ Speech problems
☐ Developmental delay	☐ Hearing problems	☐ Visual problems
☐ Hyperactivity/impulsivity	☐ Frequent ear infections	☐ Asthma
☐ Acting out behaviors	☐ Social difficulties	☐ Oppositional behaviors
☐ Running away from home	☐ Bullying other children	☐ Stealing
☐ Truancy	☐ Breaking and entering	☐ Fire setting
☐ Destruction of property	☐ Cruelty to animals	☐ Relationship Issues
☐ Sexual promiscuity	☐ Sexual Orientation Issues	☐ Gender Issues

FAMILY OF ORIGIN

Parents are: ☐ Married ☐ Separated ☐ Divorced ☐ Re-married ☐ Deceased ☐ Complicated

Child is: ☐ Biological ☐ Adopted ☐ Foster

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List all family relationships:

Person's Name	M/F	Age	Alive?	Mother, Father, Sibling, Aunt, etc.	Living at Home	Briefly Describe Him or Her

Were/are there any problems (e.g. physical, medical, psychological, academic) associated with any of the above family members?

_____

_____

SIGNIFICANT FAMILY EVENTS

Have there been any significant events in your life (e.g. moves, divorce/custody, marriages, deaths, trauma, surgeries, etc.):

ABUSE HISTORY

Were you a victim of any of the following types of abuse or witnessed any of the following? ☐ Yes ☐ No

☐ Physical Abuse ☐ Sexual Abuse ☐ Emotional Abuse ☐ Domestic Violence ☐ Neglect

Were you the victim, witness, or both? _____ Age at the time of abuse: _____ Length of abuse: _____

Did you receive help/treatment? ☐ Yes ☐ No ☐ N/A Was it reported to the authorities? ☐ Yes ☐ No

SOCIAL RELATIONSHIPS/SUPPORT SYSTEMS

Do you have at least one close friendship? ☐ Yes ☐ No

If yes, how many and who? _____

Do you currently have a support system? ☐ Yes ☐ No

If yes, whom does it include? _____

HOBBIES AND SPECIAL INTERESTS

Do you have any hobbies or special interest? ☐ Yes ☐ No

If yes, what are they? _____

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MEDICAL HISTORY

List any food or medication allergies: _____

List any surgeries and year: _____

Sleep Pattern

☐ No known problems ☐ Interrupted Sleep: if yes # of interruptions per night: _____
☐ Early awakening ☐ Insomnia ☐ Hypersomnia ☐ Frequent awakening
☐ Difficulty falling asleep ☐ Sleep apnea ☐ Sleep study: if yes, approximate date: _____

Neurological

☐ No known problems ☐ Seizure ☐ Tinnitus ☐ Headaches
☐ Tremors ☐ Stroke ☐ Paralysis ☐ Head injury
☐ Right side weakness ☐ Left side weakness ☐ Dystonia ☐ Unsteady gait
☐ Tardive dyskinesia ☐ Paresthesia ☐ Akathisia ☐ Other: _____

Cardiovascular

☐ No known problems ☐ Edema ☐ Heart surgery ☐ Palpitations
☐ Congenital defects ☐ Hypertension ☐ Hypotension ☐ Angina
☐ Chest pain ☐ Heart attack (MI) ☐ Clotting problems ☐ Other: _____

Respiratory

☐ No known problems ☐ Non-smoker ☐ Asthma ☐ Dyspnea
☐ Cough ☐ Productive cough ☐ COPD ☐ Smoker

Gastrointestinal

☐ No known problems ☐ GERD ☐ Ulcer ☐ IBS
☐ Constipation ☐ Diarrhea ☐ Nausea ☐ Vomiting
☐ Difficulty chewing ☐ Other: _____

Endocrine

☐ No known problems ☐ Adrenal ☐ Pituitary ☐ Diabetes
☐ Thyroid ☐ Other: _____

Urinary

☐ No known problems ☐ Bed wetting ☐ Holding ☐ Other: _____

Reproductive

☐ No known problems ☐ Sexually active ☐ Unprotected sex ☐ Use birth control
☐ Pregnant ☐ Hx of abortion ☐ Hx of miscarriage(s) ☐ Endometriosis
☐ PCOS ☐ Other: _____

Infectious Disease

☐ No known problems ☐ AIDS/HIV ☐ Hepatitis ☐ Herpes
☐ Syphilis ☐ Chlamydia ☐ Other STD: _____
☐ Chicken pox ☐ Mononucleosis ☐ MRSA

Muscular-Skeletal

☐ No known problems ☐ Deformities ☐ Scoliosis ☐ Other: _____

MEDICAL PROVIDERS

List all doctors, hospitals, counselors, or residential/in-patient care you have recently received treatment from:

Name: _____ Reason: _____

Name: _____ Reason: _____

Name: _____ Reason: _____

Name: _____ Reason: _____

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MEDICATIONS/SUPPLEMENTS

Name, dosage, frequency, problem: _____

Name, dosage, frequency, problem: _____

Name, dosage, frequency, problem: _____

Name, dosage, frequency, problem: _____

PAIN ASSESSMENT

Do you currently have any pain? ☐ Yes ☐ No Frequency: _____ Intensity (1-10): _____

Origination of pain? _____ Where is your pain located? _____

What causes/increases the pain? _____

What decreases/relieves the pain? _____

CURRENT STATUS

Please check any of the following problems that apply to either you or your family:

Weight loss/gain:	☐ You	☐ Family	Self-esteem issues:	☐ You	☐ Family
Eating disorder(s):	☐ You	☐ Family	Hyperactivity:	☐ You	☐ Family
Stress/anxiety:	☐ You	☐ Family	Racing thoughts:	☐ You	☐ Family
Nervousness/panic:	☐ You	☐ Family	Unwanted thoughts:	☐ You	☐ Family
Fear/phobia(s):	☐ You	☐ Family	Hallucinations:	☐ You	☐ Family
Dreams/nightmares:	☐ You	☐ Family	Impulse control:	☐ You	☐ Family
Sleep problems:	☐ You	☐ Family	Obsessions/compulsions:	☐ You	☐ Family
Mood swings:	☐ You	☐ Family	Sexual acting out:	☐ You	☐ Family
Withdrawal/isolation:	☐ You	☐ Family	Pornography:	☐ You	☐ Family
Depression:	☐ You	☐ Family	Infidelity:	☐ You	☐ Family
Apathy/lethargy:	☐ You	☐ Family	Anger:	☐ You	☐ Family
Hope/helplessness	☐ You	☐ Family	Aggression:	☐ You	☐ Family
Grief/loss:	☐ You	☐ Family	Spiritual abuse:	☐ You	☐ Family
Terminal illness:	☐ You	☐ Family	Rape/incest:	☐ You	☐ Family
Loneliness:	☐ You	☐ Family	PTSD/trauma	☐ You	☐ Family
Shyness:	☐ You	☐ Family	Guilt/shame:	☐ You	☐ Family
Inferiority feelings:	☐ You	☐ Family	Communication:	☐ You	☐ Family

ADDITIONAL INFORMATION

Please provide any additional information that you feel is relevant to this assessment:

SIGNATURE SECTION

_____ _____

Signature of Client, Parent, or Legal Guardian Date

_____ _____

Printed Name of Client, Parent, or Legal Guardian Relationship to the Client/Minor